AO 441 Summons in a Civil Action

United States District Court

SOUTHERN DISTRICT OF CALIFORNIA

Brian Szasz, Individually

Plaintiff

V.

County of San Diego; Correctional Healthcare Partners, Inc., Arim Lee, Dr. Montgomery, Dr. Nas Rafi, Jonathan Symmonds, Serina Hood, and Does 1-10, inclusive

Defendant

Civil Action No. 22CV1054-BTM-MDD

0778635

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)*

County of San Diego
1600 Pacific Highway, Room 335
San Diego, CA 92101

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) - or 60 days if you are the United States or a United States agency, or an office or employee of the United States described in Fed. R. Civ. P. 12(a)(2) or (3) - You must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Danielle R. Pena
501 West Broadway, Suite 1480
San Diego, CA 92101
(619) 826-8060

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

Date: 7/19/22

UNITED STATES DISTRICT COURT SOUTHERN DISTRICT OF CALIFORNIA

John Morrill
CLERK OF COURT

S/ C. Thepkaysone
Signature of Clerk or Deputy Clerk

COSD BOARD OF SUPERVISORS
2022 AUG 4 PM3:59 IN PERSON
Student worker

Civil Action No. 22CV1054-BTM-MDD Date Issued: 7/19/22

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4(1))

This summons for *(name of individual and title, if any)* County of San Diego

was received by me on *(date)* July 19, 2022.

I personally served the summons on the individual at *(place)* _____

_____ on *(date)* _____; or

I left the summons at the individual's residence or place of abode with *(name)* _____

_____, a person of suitable age and discretion who resides there,

on *(date)* _____, and mailed a copy to the individual's last known address; or

I served the summons on *(name of the individual)* Athena Lazos, who is

designated by law to accept service of process on behalf of *(name of organization)* _____

County of San Diego on *(date)* 8/4/2022; or

I returned the summons unexecuted because _____; or

Other *(specify)*:

My fees are $ 0 for travel and $ 0 for services, for a total of $ 0.

I declare under penalty of perjury that this information is true.

Date: August 4, 2022

Server's Signature

Leanna Pierce, Legal Assistant

Printed name and title

501 West Broadway, Suite 1480, San Diego, CA 92101

Server's address

NOTICE OF RIGHT TO CONSENT TO TRIAL BY A UNITED STATES MAGISTRATE JUDGE

IN ACCORDANCE WITH THE PROVISION OF 28 USC 636(C) YOU ARE HEREBY NOTIFIED THAT A U.S. MAGISTRATE JUDGE OF THIS DISTRICT MAY, UPON CONSENT OF ALL PARTIES, CONDUCT ANY OR ALL PROCEEDINGS, INCLUDING A JURY OR NON-JURY TRIAL, AND ORDER THE ENTRY OF A FINAL JUDGMENT.

YOU SHOULD BE AWARE THAT YOUR DECISION TO CONSENT OR NOT CONSENT IS ENTIRELY VOLUNTARY AND SHOULD BE COMMUNICATED SOLELY TO THE CLERK OF COURT. ONLY IF ALL PARTIES CONSENT WILL THE JUDGE OR MAGISTRATE JUDGE WHOM THE CASE HAS BEEN ASSIGNED BE INFORMED OF YOUR DECISION.

JUDGMENTS OF THE U.S. MAGISTRATE JUDGES ARE APPEALABLE TO THE U.S. COURT OF APPEALS IN ACCORDANCE WITH THIS STATUTE AND THE FEDERAL RULES OF APPELLATE PROCEDURE.

JS 44 (Rev. 12/12)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS
BRIAN SZASZ, Individually

(b) County of Residence of First Listed Plaintiff San Diego, CA
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Danielle R. Pena
PHG Law Group
501 West Broadway, Suite 1480, San Diego, CA 92101, 619-826-8060

DEFENDANTS
COUNTY OF SAN DIEGO; CORRECTIONAL HEALTHCARE PARTNERS, INC., ARIM LEE, DR. MONTGOMERY, DR. NAS RAFI, JONATHAN SYMMONDS, SERINA HOOD, and DOES 1-10, inclusive

County of Residence of First Listed Defendant San Diego, CA
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

'22CV1054 BTM MDD

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☒ 1	☒ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

CONTRACT	TORTS		FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
☐ 110 Insurance	PERSONAL INJURY	PERSONAL INJURY	☐ 625 Drug Related Seizure of Property 21 USC 881	☐ 422 Appeal 28 USC 158	☐ 375 False Claims Act
☐ 120 Marine	☐ 310 Airplane	☐ 365 Personal Injury - Product Liability	☐ 690 Other	☐ 423 Withdrawal 28 USC 157	☐ 400 State Reapportionment
☐ 130 Miller Act	☐ 315 Airplane Product Liability	☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability		PROPERTY RIGHTS	☐ 410 Antitrust
☐ 140 Negotiable Instrument	☐ 320 Assault, Libel & Slander	☐ 368 Asbestos Personal Injury Product Liability		☐ 820 Copyrights	☐ 430 Banks and Banking
☐ 150 Recovery of Overpayment & Enforcement of Judgment	☐ 330 Federal Employers' Liability	PERSONAL PROPERTY		☐ 830 Patent	☐ 450 Commerce
☐ 151 Medicare Act	☐ 340 Marine	☐ 370 Other Fraud	LABOR	☐ 840 Trademark	☐ 460 Deportation
☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)	☐ 345 Marine Product Liability	☐ 371 Truth in Lending	☐ 710 Fair Labor Standards Act	SOCIAL SECURITY	☐ 470 Racketeer Influenced and Corrupt Organizations
☐ 153 Recovery of Overpayment of Veteran's Benefits	☐ 350 Motor Vehicle	☐ 380 Other Personal Property Damage	☐ 720 Labor/Management Relations	☐ 861 HIA (1395ff)	☐ 480 Consumer Credit
☐ 160 Stockholders' Suits	☐ 355 Motor Vehicle Product Liability	☐ 385 Property Damage Product Liability	☐ 740 Railway Labor Act	☐ 862 Black Lung (923)	☐ 490 Cable/Sat TV
☐ 190 Other Contract	☐ 360 Other Personal Injury		☐ 751 Family and Medical Leave Act	☐ 863 DIWC/DIWW (405(g))	☐ 850 Securities/Commodities/ Exchange
☐ 195 Contract Product Liability	☐ 362 Personal Injury - Medical Malpractice		☐ 790 Other Labor Litigation	☐ 864 SSID Title XVI	☐ 890 Other Statutory Actions
☐ 196 Franchise			☐ 791 Employee Retirement Income Security Act	☐ 865 RSI (405(g))	☐ 891 Agricultural Acts
REAL PROPERTY	CIVIL RIGHTS	PRISONER PETITIONS	IMMIGRATION	FEDERAL TAX SUITS	☐ 893 Environmental Matters
☐ 210 Land Condemnation	☒ 440 Other Civil Rights	Habeas Corpus:	☐ 462 Naturalization Application	☐ 870 Taxes (U.S. Plaintiff or Defendant)	☐ 895 Freedom of Information Act
☐ 220 Foreclosure	☐ 441 Voting	☐ 463 Alien Detainee	☐ 465 Other Immigration Actions	☐ 871 IRS—Third Party 26 USC 7609	☐ 896 Arbitration
☐ 230 Rent Lease & Ejectment	☐ 442 Employment	☐ 510 Motions to Vacate Sentence			☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
☐ 240 Torts to Land	☐ 443 Housing/ Accommodations	☐ 530 General			☐ 950 Constitutionality of State Statutes
☐ 245 Tort Product Liability	☐ 445 Amer. w/Disabilities - Employment	☐ 535 Death Penalty			
☐ 290 All Other Real Property	☐ 446 Amer. w/Disabilities - Other	Other:			
	☐ 448 Education	☐ 540 Mandamus & Other			
		☐ 550 Civil Rights			
		☐ 555 Prison Condition			
		☐ 560 Civil Detainee - Conditions of Confinement			

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
U.S.C. 1983

Brief description of cause:
14th Amendment Violation, Negligence, Intentional Infliction of Emotional Distress, Battery

VII. REQUESTED IN COMPLAINT: ☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P. **DEMAND $** CHECK YES only if demanded in complaint: **JURY DEMAND:** ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY *(See instructions)*: JUDGE _____ DOCKET NUMBER _____

DATE
07/19/2022

SIGNATURE OF ATTORNEY OF RECORD
s/ Danielle R. Pena

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

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501 West Broadway, Suite 1480
San Diego, CA 92101
Telephone: (619) 826-8060
Facsimile: (619) 826-8065

Attorneys for Plaintiff Brian Szasz

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

BRIAN SZASZ, Individually,

Plaintiff,

v.

COUNTY OF SAN DIEGO; CORRECTIONAL HEALTHCARE PARTNERS, INC., ARIM LEE, DR. MONTGOMERY, DR. NAS RAFI, JONATHAN SYMMONDS, SERINA HOOD, and DOES 1-10, inclusive,

Defendants.

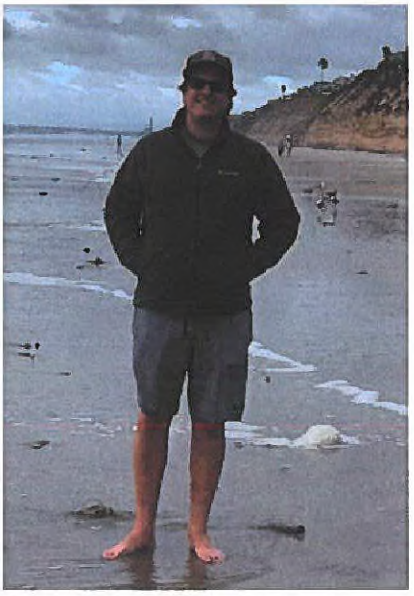
Case No. '22CV1054 BTM MDD

COMPLAINT FOR:

1. **14th AMENDMENT – OBJECTIVE INDIFFERENCE**
2. **14th AMENDMENT – ADA AND ARTICLE 1, SECTIONS 7 AND 17 OF CALIFORNIA CONSTITUTION**
3. **14th AMENDMENT – INADEQUATE CUSTOM AND POLICY**
4. **NEGLIGENCE**
5. **INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS**
6. **BATTERY**

I.

FACTUAL ALLEGATIONS SUPPORTING THE COMPLAINT



1. Plaintiff, Brian Szasz (herein "Mr. Szasz"), is 36 years old. He was born in Princeton, New Jersey, and moved in San Diego over ten years ago. At the age of 18 months, Mr. Szasz was diagnosed as a Type 1 diabetic. At the age of 15, he was diagnosed with Asperger's syndrome. Mr. Szasz is extremely intelligent but socially inept in most ways. Putting his intelligence to work, Mr. Szasz is a Padres fanatic and spends most of his days researching team and player stats.

2. In the past three years, Mr. Szasz's proliferative diabetes has resulted in a diagnosis of diabetic retinopathy. Diabetic retinopathy results in retina detachment and total blindness. According to Mr. Szasz's Vitreoretinal Surgeon, Dr. Mozayan, Mr. Szasz's diabetes has caused significant deterioration in the retinas of both eyes, which if not properly treated by laser surgery will undoubtedly lead to permanent blindness. As such, Mr. Szasz received frequent laser treatments from Dr. Mozayan to treat the blood vessels at the back of both eyes to promote vessel strength and prevent blindness.

3. On June 30, 2021, Mr. Szasz was detained at Vista Detention Facility (herein "VDF") in connection with online stalking charges pressed against him. Being socially stunted, Mr. Szasz would often find friendships online. During a particular exchange a heated discussion ensued that resulted in physical threats made by all involved parties.

4. Upon intake at VDF, Mr. Szasz informed intake staff that he suffered from Type 1 diabetes (insulin dependent) and diabetic retinopathy. As a result. Mr. Szasz was assigned to be evaluated by a nurse practitioner the following day.

5. During that evaluation, Mr. Szasz informed Defendant Arim Jayne Lee that he needed an ophthalmology consultation immediately. He informed the medical provider that he required laser treatments or would go blind. Based on limited medical records, Plaintiff is ignorant of whether Defendant Arim Jayne Lee failed to order the referral or elevate the matter to her supervisor, Defendant Dr. Montgomery. If she did elevate the matter with her superior, Defendant Dr. Montgomery failed to order the ophthalmologist consultation on an urgent basis or provide continuing medication.

6. According to Mr. Szasz, he was not prescribed the correct insulin regimen despite having Mr. Szasz's medical and pharmaceutical records. Nor was Mr. Szasz given Lumigan, the eyedrop medication prescribed for Mr. Szasz's retinopathy. Meaning, from the very beginning of his detainment, Mr. Szasz's diabetes was not properly treated, and his diabetic retinopathy was completely ignored. At this time, Plaintiff is unaware of what medical provider(s) were responsible for ensuring congruent treatment while Mr. Szasz was in the *care* and custody of the County.

7. During the intake process on June 30, 2021, Mr. Szasz took notice of another inmate that was acting bizarre and aggressive, i.e., speaking to himself and yelling about the devil. Mr. Szasz was housed with this inmate in cell 26. At the time he was being housed with the inmate, Mr. Szasz expressed to a DOE housing deputy that he felt uncomfortable being housed with this particular inmate. Mr. Szasz's concerns were ignored and met with expletives. Based on information and belief, Defendant County and its DOE housing and classification deputies were on notice that DOE inmate was assaultive and unstable when they housed him with Mr. Szasz. Notably, DOE defendants also know Mr. Szasz is a vulnerable inmate that suffered from autism and severe medical conditions.

8. A day or two later, on July 2, 2021, DOE inmate brutally attacked Mr. Szasz, claiming he needed to exorcise Mr. Szasz's demons. The inmate struck Mr.

Szasz in his face multiple times breaking several facial bones. DOE inmate then viciously bit Mr. Szasz on the neck and hand. During the attack, the inmate bent back Mr. Szasz's thumb and broke it.

9. Following the attack, Mr. Szasz was taken to the medical center where he was treated by Defendant Jonathan Symmonds. Defendant Symmonds failed to properly or thoroughly evaluate Mr. Szasz. Had Defendant Symmonds properly assessed Mr. Szasz, he would have noted the various broken facial bones and Mr. Szasz's thumb, which was hanging on by the skin. Mr. Szasz was sent back to housing with no follow up order or wound care orders. Furthermore, Defendant Jonathan Symmonds failed to investigate who bit Mr. Szasz and determine whether DOE inmate was immunized or checked for infectious diseases.

10. The following day, July 3, 2021, Mr. Szasz was evaluated by Defendant Dr. Nas Rafi. Mr. Szasz complained of the immense pain in his right hand. However, his pleas were ignored again. Due to Mr. Szasz's level of complaints, Defendant Rafi permitted the nursing staff to order a thumb split but implied that it was not medically indicated. Defendant Rafi did not order follow up care or wound care despite Mr. Szasz's obvious broken bones and an *open* wound on the palm/thumb area of Mr. Szasz's right hand.

11. For the next few days, Mr. Szasz constantly complained to unknown DOE correctional and medical staff regarding the immense pain he was feeling in his right hand. He also told unknown DOE staff that his thumb was getting worse and appeared infected. No one cared or attempted to provide care.

12. Despite asking for medical help multiple times a day, Mr. Szasz was not seen by medical until July 8, 2021. He was summoned to the medical center to have the thumb splint applied. At that time, Mr. Szasz was evaluated by a different medical provider, Nurse Practitioner Joseph Carroll ("NP Carroll"). NP Carroll immediately opined that Mr. Szasz was suffering from a bone infection in his thumb. According to the medical note, Mr. Szasz's thumb/palm was red, swollen,

oozing, and had no range of motion. Mr. Szasz was urgently sent to Tri-City Medical Center ("TCMC").

13. The doctors at TCMC diagnosed Mr. Szasz with flexor tenosynovitis. Flexor tenosynovitis is a severe infection within the hand. According to the TCMC medical providers, flexor tenosynovitis requires urgent treatment to preserve a viable and functioning thumb. Delayed diagnosis and treatment will result in a poor recovery. On that same day, Mr. Szasz underwent urgent surgery in his hand. It was then determined that Mr. Szasz contracted MRSA in his hand. In short, because jail medical providers ignored Mr. Szasz's obviously broken bone and open wound, coupled with their failure to order wound care throughout a six-day period, and investigate the origin of the bite to Mr. Szasz's hand, Mr. Szasz contracted MRSA.

14. While at TCMC, Mr. Szasz was treated by Dr. Seiden, an orthopedic surgeon. Dr. Seiden performed the urgent surgery and determined that Mr. Szasz had developed sepsis and was short of death. Mr. Szasz was treated at TCMC for the next week. Mr. Szasz's discharge paperwork clearly states Mr. Szasz wound was *nearly* closed. TCMC provided the jail with specific medical and wound care orders to be followed. The discharge order directed the County to follow up with Dr. Seiden in two-four weeks. The discharge paperwork also directed jail staff to provide Mr. Szasz with a different insulin regimen and Lumigan, the eye drops prescribed for Mr. Szasz's retinopathy.

15. When Mr. Szasz was transported back to VDF, Defendant Rafi reviewed the TCMC discharge paperwork. Defendant Rafi did not detail the medication needed nor did he prescribe the proper wound care as was used at TCMC. He also failed to prescribe medication to treat Mr. Szasz's retinopathy.

16. Limited medical records indicate that when Mr. Szasz returned to VDF he was never treated for his retinopathy, especially not as prescribed by Dr. Mozayan, Mr. Szasz's treating provider. Notably, the medical records indicate that

Mr. Szasz recorded extremely high blood sugar levels nearly every day, sometimes twice a day, always 300+. According to Mr. Szasz, he was given inconsistent and incorrect insulin doses by DOE nurses that did not know the difference between fast acting and slow-release insulin. In fact, on a few occasions, Mr. Szasz had to refuse medical treatment because nurses were attempting to give him the wrong medication. Due to grossly inadequate diabetic care, under the supervision of Defendant Rafi, Mr. Szasz began suffering from ocular complications.

17. In and around July and September of 2021, Mr. Szasz's father, Leslie Szasz, constantly wrote letters to the jail and County officials requesting intervention and treatment on behalf of his son. He was continually ignored. Leslie Szasz would also call the jail in an effort to obtain the eye treatments his son so desperately needed. On multiple occasions Leslie Szasz spoke with Head Nurse, Defendant Serina Hood. Defendant Hood was on notice via Leslie Szasz, and the paperwork from San Diego Retina Center, that Mr. Szasz desperately needed routine laser treatments or would go blind. Defendant Hood ensured that Leslie Szasz that his son was receiving proper treatment knowing that he had yet to be referred to an ophthalmologist for laser treatments.

18. Inmate request forms confirm that Mr. Szasz was constantly notifying the jail that he needed a retinopathy laser treatments because his eyesight was worsening. Mr. Szasz's constant pleas and medical requests were ignored by DOE deputies and medical staff.

19. On August 6, 2021, Mr. Szasz was evaluated via telemedicine by Dr. Seiden, the orthopedic surgeon that performed the first surgery on Mr. Szasz's hand. Dr. Seiden opined that the wound was *not fully healed* and needed to be monitored **very closely.** At that time, Dr. Seiden did not think further surgical intervention was indicated but did order physical therapy to help Mr. Szasz regain mobility in his hand.

/ / /

20. However, from that date on, Mr. Szasz's wound care decreased from once a day to once every few days. When Mr. Szasz did receive wound care it was below the standard of care because DOE medical staff failed to follow the wound care orders from TCMC, which included use of Bactrim. Furthermore, despite the order for physical therapy, Mr. Szasz was wholly denied any treatment.

21. In short, during August and September of 2021, Mr. Szasz required serious medical intervention with regard to his right hand and his diabetic complications. According to Mr. Szasz, he submitted dozens of medical request forms to this effect. On August 15, 2021, Mr. Szasz moved from medical housing and re-housed in disciplinary housing. Based on information and belief, Mr. Szasz was removed from medical housing due to the number of complaints he was lodging with medical and correctional staff.

22. After being ignored inside VDF, and after having his father write several letters without a response, Mr. Szasz's criminal lawyer sought a court order from Judge Washington relative to Mr. Szasz's retinopathy treatment.

23. On September 2, 2021, Judge Washington ordered VDF to obtain the treatment needed, as declared by Dr. Mozayan. Despite Judge Washington's order, the County and its medical staff, supervised by Defendant Rafi, failed to follow the court order. In fact, Judge Washington ordered that Mr. Szasz was to receive laser treatments as indicated medical professionals.

24. During Mr. Szasz's first treatment at UCSD, Mr. Szasz was told he would need weekly treatments for his right eye and periodic treatments for his left eye. This order is indicated in the limited medical records Mr. Szasz received. Shockingly, the County, including all medical Defendants identified above, only authorized **one** treatment to **one** eye! Mr. Szasz never received follow-up treatment despite Judge Washington's clear order otherwise. As a result of Defendants' epic failure to treat Mr. Szasz's retinopathy, his vision deteriorated at an accelerated

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rate. Mr. Szasz now has blurred vision, which is a precursor to blindness in both eyes.

25. During Mr. Szasz's zealous attempts to obtain laser treatments for his retinopathy, the wound care for his right hand stopped. Mr. Szasz developed another MRSA infection in his right hand.

26. Due to limited medical records, Plaintiff is ignorant of the identities of the medical providers that failed to continue indicated treatment despite multiple requests from Mr. Szasz, and his father Leslie, regarding the worsening condition of Mr. Szasz's hand.

27. It took major oozing and no range of movement for medical staff to intervene. Ultimately, Mr. Szasz was sent to TCMC on August 19, 2021. Mr. Szasz underwent another urgent surgery. Again, the unknown TCMC doctor told Mr. Szasz that the webspace in his hand was growing MRSA. He told Mr. Szasz that he would need continual oversight for approximately 2-3 weeks to ensure there was not a re-occurrence of an infection. However, against the advice of the unknown medical doctor, DOE deputies, at the direction of DOE medical staff, including Defendant Rafi, removed Mr. Szasz from TCMC against medical directive.

28. Based on an incomplete medical record from the jail, Plaintiff is unaware of the follow-on care, if any. However, prior to Mr. Szasz's transfer to prison in May of 2022, Mr. Szasz underwent two more surgeries, totaling to four surgeries for his right hand. To date, Mr. Szasz has no movement if his right thumb, mainly due to wholly inadequate care and a complete failure to provide physical therapy. Even today, Mr. Szasz's entire right hand is fraught with pain. The pain is now so severe and prolonged that Mr. Szasz has been suffering from debilitating depression.

29. Based on Defendants' failures detailed above, Mr. Szasz has suffered from irreparable blindness and loss of use in his right hand.

30. Furthermore, in addition to the indifference and negligence displayed by Defendants, the County itself, and it contracted medical group, Correctional Healthcare Partners, Inc. ("CHP"), are responsible for Mr. Szasz's injuries because they have fostered an environment of apathy regarding medical care for inmates. According to a class action lawsuit filed against the County and CHP, "Inmates are unnecessarily suffering and dying in the Jail facilities due to extraordinary dangerous and deadly conditions, polices, and practices that have been allowed to persist for many years." The class action suit points out: "The Jail's death rate in 2021 was almost triple the national rate in jails—154 per 100,000 people—according to the most recent data from the Bureau of Justice Statistics, and more than double the 2011-2020 death rates in other large California jails. New York City's Rikers Island—which has received widespread national media attention and has a larger average daily population than the San Diego County Jail—had *fewer* deaths (16) than the San Diego County Jail (18) last year."

31. Specifically, the County and CHP have maintained constitutionally inadequate intake practices which fail to identify inmates suffering from severe co-morbidity conditions. The County and CHP have also failed to implement protocols that ensure that inmates that are later identified with co-morbidity conditions are congruently treated for all severe conditions. Defendants have also failed to ensure that the medical treatments inmates receive outside of custody, by their primary care physicians, remain consistent and congruent when inmates are detained in Jail. Lastly, Defendants failed to implement protocols ensuring that inmates who were given a referral to a specialist get treated by the specialist. Generating a referral does not relieve Defendants of their duty to provide adequate care. Rather, the County and CHP intentionally failed to implement follow-up protocols that ensure referrals and consultation occur, and in a timely manner.

32. Knowing that inmates are not receiving the necessary treatment, the County and CHP have doubled down on their indifference by intentionally

understaffing the jails. According to the class action lawsuit, "An October 2021 letter from the Service Employees International Union ("SEIU") Local 221, which represents Jail health care workers, to the Citizens Law Enforcement Review Board ("CLERB") explained that understaffing created "dangerous and inhumane" conditions for incarcerated people and medical staff alike. As of late 2021, 216 medical positions at the Jail—more than 41% of authorized positions—remained vacant, and existing medical staff have been on mandatory overtime for months."

33. For these reasons, Defendants are liable and responsible for Mr. Szasz's loss of use of his right hand and the loss of vision that will assuredly lead to total blindness. Defendants are also responsible for the severe emotional distress that Mr. Szasz has endured as a result of Defendants' conduct.

II.

JURISDICTION AND VENUE

34. This action arises under the Constitution and laws, including Article III, Section 1 of the United States Constitution and is brought pursuant to 42 U.S.C. section 1983. The Jurisdiction of this court is invoked pursuant to 28 U.S.C. section 1331. State law claims are alleged as well, over which Plaintiff invokes the Court's supplemental jurisdiction.

35. This case is instituted in the United States District Court for the Southern District of California pursuant to 28 U.S.C. section 1391, as the judicial district in which all relevant events and omissions occurred and in which Defendants maintain offices, work, and/or reside.

III.

THE PARTIES

36. Plaintiff Brian Szasz was a resident of San Diego County in the State of California and a citizen of the United States at all times relevant to this complaint. He was injured and inadequately treated at Vista Detention Facility which is located in the County of San Diego.

37. Defendant Arim Jayne Lee was working at VDF as a contracted medical provider. Based on information and belief, Defendant Arim Jayne Lee was employed by CHP. Based on information and belief, Defendant Arim Jayne Lee lives and works in the County of San Diego at all times mentioned herein, and committed the culpable acts against Plaintiff in the same County. Plaintiff did not discover the culpable act done by Defendant Lee until Plaintiff received incomplete medical jail records on September 29, 2021.

38. Defendant Dr. Montgomery was working at VDF as a contracted medical provider. Based on information and belief, Defendant Dr. Montgomery was employed by CHP. Based on information and belief, Defendant Dr. Montgomery lives and works in the County of San Diego at all times mentioned herein, and committed the culpable acts against Plaintiff in the same county. Plaintiff did not discover the culpable act done by Defendant Montgomery until Plaintiff received incomplete medical jail records on September 29, 2021.

39. Defendant Dr. Nas Rafi was working at VDF as a contracted medical provider. Based on information and belief, Defendant Dr. Nas Rafi was employed by CHP. Based on information and belief, Defendant Dr. Nas Rafi lives and works in the County of San Diego at all times mentioned herein, and committed the culpable acts against Plaintiff in the same county. Plaintiff did not discover the culpable act done by Defendant Rafi until Plaintiff received incomplete medical jail records on September 29, 2021.

40. Defendant Correctional Healthcare Partners, Inc. ("CHP") is, and at all times mentioned herein was, the contracted medical provider for all the jails in San Diego County. CHP employed and/or was the principle of Defendants Arim Jayne Lee, Dr. Montgomery, and Dr. Nas Rafi. Defendants Dr. Rafi, Dr. Montgomery, and Lee were employees and/or agents of CHP and were acting within the course of scope of employment when they provided grossly inadequate and indifferent care to Mr. Szasz. Based on information and belief, CHP is located in San Diego County.

For these reasons, CHP is vicariously liable. CHP is also an agent of the County and as such is sued directly for their inadequate policies, practices, training and supervision regarding inmates in severe medical need.

41. Defendant Jonathan Symmonds was working at VDF as a registered nurse and employee of the County. Based on information and belief, Defendant Jonathan Symmonds lives and works in the County of San Diego at all times mentioned herein, and committed the culpable acts against Plaintiff in the same county. Plaintiff did not discover the culpable act done by Defendant Symmonds until Plaintiff received incomplete medical jail records on September 29, 2021.

42. Defendant Serina Hood was working at VDF as a registered nurse and employee of the County. Based on information and belief, Defendant Hood lives and works in the County of San Diego at all times mentioned herein, and committed the culpable acts against Plaintiff in the same county. Plaintiff did not discover the culpable act done by Defendant Hood until Plaintiff received incomplete medical jail records on September 29, 2021.

43. Defendant County of San Diego ("County") is, and at all times mentioned herein was, a public entity authorized by law to establish certain departments responsible for enforcing the laws and protecting the welfare of San Diego County citizens. At all times mentioned herein, Defendant County was responsible for overseeing the operation, management, and supervision of the San Diego County jails such as VDF, as well as its Corrections Deputies, Medical Staff, and inmates. The County is also responsible for developing, implementing, and amending jail policies, procedures, and training. Regardless of its contract with third party medical groups, the county has a non-delegable duty to provide adequate medical care and cannot contract away that obligation to third-party medical groups.

44. The names of the other individual Sheriff's Deputies who are responsible for Plaintiff's injuries are currently unknown to Plaintiff. As such,

these individuals are sued herein as DOES 1-10, and referred to herein as "DOE Deputy/Nurse/Medical Defendants."

45. The true names and capacities whether individual, corporate, associate or otherwise, of defendants named herein as DOES 1-10 are unknown to Plaintiff, who therefore sue said defendants by said fictitious names. Plaintiff will amend this complaint to show said defendants' true names and capacities when the same have been ascertained. Plaintiff is informed and believes and thereon alleges that all defendants sued herein, and DOES, worked in concert and conspired in some fashion. Each Defendant is in some manner responsible for the acts and injuries of each other, as alleged herein.

46. At all times mentioned herein Defendants named herein as DOES 1-10 were employees and/or independent contractors of Defendant San Diego County and in doing the acts hereinafter described acted within the course and scope of their employment. The acts of all defendants and each of them were also done under the color and pretense of the statutes, ordinances, and regulations of the County of San Diego and the State of California. In committing the acts and/or omissions alleged herein, all defendants acted under color of authority and/or under color of law. Plaintiff sues all public employees named as Defendants in their individual capacities.

IV.

FIRST CAUSE OF ACTION

42 U.S.C. Section 1983 – 14th Amendment – Objective Indifference

[By Brian Szasz Against NP Lee, Dr. Montgomery, RN Symmonds, Dr. Rafi, RN Hood, and DOE Deputy/Nurse Defendants 1-10]

47. Plaintiff realleges and incorporates by reference all paragraphs stated above, as though fully set forth herein.

48. Under the Fourteenth Amendment, a pretrial detainee has the right to constitutionally adequate medical care.

49. As detailed above, Defendants NP Lee and Dr. Montgomery were informed by Mr. Szasz that he was a Type 1 diabetic and suffered from diabetic retinopathy. Mr. Szasz explicitly informed Defendants that he needed an ophthalmologist consultation immediately. In response, both Defendants failed to reasonably respond. Neither Defendant ensured Mr. Szasz would receive the proper insulin regimen, eyedrops, or consultation. Rather, Defendants failed to act entirely.

50. After intake, according to Mr. Szasz, he was not prescribed the correct insulin regimen despite having Mr. Szasz's medical and pharmaceutical records. Nor was Mr. Szasz given Lumigan, the eyedrop medication prescribed for Mr. Szasz's retinopathy. Meaning, from the very beginning of his detainment, Mr. Szasz's diabetes was not properly treated, and his diabetic retinopathy was completely ignored. As a result of poor diabetes management, Mr. Szasz daily blood sugar levels were 300+! The failure to provide adequate insulin treatment is directly linked to the ocular complications Mr. Szasz experienced at VDF.

51. Limited medical records indicate that Mr. Szasz was never treated for his retinopathy, especially not as prescribed by Dr. Mozayan, Mr. Szasz's treating ocular provider. According to the limited medical records, Mr. Szasz recorded extremely high blood sugar levels nearly every day, sometimes twice a day, always 300+. According to Mr. Szasz, he was given inconsistent and incorrect insulin doses by DOE nurses that did not know the difference between fast acting and slow-release insulin. In fact, on a few occasions, Mr. Szasz had to refuse medical treatment because nurses were attempting to give him the wrong medication. Due to grossly inadequate diabetic care, under the believed supervision of Defendant Rafi, Mr. Szasz began suffering from ocular complications.

52. In and around July and September of 2021, Mr. Szasz's father, Leslie Szasz, wrote countless letters to the jail and County officials requesting intervention and treatment on behalf of his son. He was continually ignored. Leslie Szasz

would also call the jail in an effort to obtain the eye treatments his son so desperately needed. On multiple occasions Leslie Szasz spoke with Head Nurse, Defendant Serina Hood. Defendant Hood was on notice via Leslie Szasz, and the paperwork from San Diego Retina Center, that Mr. Szasz desperately needed routine laser treatments or would go blind. Defendant Hood misrepresented the truth by ensuring Leslie Szasz that his son was receiving proper treatment knowing that he had yet to be referred to an ophthalmologist for laser treatments.

53. In and around the same time, Mr. Szasz would submit inmate request forms notifying jail personnel that he needed retinopathy laser treatments because his eyesight was worsening. Not only were Mr. Szasz's constant pleas and medical requests ignored by DOE deputies and medical staff, but Mr. Szasz was also punished by DOE jail staff in the form of being placed in disciplinary housing. Of course, Mr. Szasz provided no reason to be placed in a disciplinary cell other than "being a fucking pain in the ass," as stated by one DOE deputy. While being placed in the "hole," Mr. Szasz was denied recreation time and shower time. The condition of the hole was filthy and inhumane. All available activities were withheld based on his, and Leslie Szasz's, continued pleas for medical attention.

54. After being ignored inside VDF, and after having his father write several letters without a response, Mr. Szasz's criminal lawyer sought a court order from Judge Washington relative to Mr. Szasz's retinopathy treatment.

55. On September 2, 2021, Judge Washington ordered VDF to obtain the treatment needed, as declared by Dr. Mozayan. Plaintiff is currently unaware of what DOE defendants are responsible for processing and ensuring that court orders regarding medical directives are followed.

56. Despite Judge Washington's order, the County and its medical staff, supervised by Defendant Rafi, failed to follow the court order. In fact, Judge Washington ordered that Mr. Szasz was to receive laser treatments as indicated medical professionals.

57. During Mr. Szasz's first and only treatment at UCSD, Mr. Szasz was told he would need weekly treatments for his right eye and periodic treatments for his left eye. This order is indicated in the limited medical records Mr. Szasz received. Shockingly, the County, including all medical Defendants identified above, only authorized **one** treatment to **one** eye! Mr. Szasz never received follow-up treatment despite Judge Washington's clear order otherwise. As a result of Defendants' intentional failure to treat Mr. Szasz's retinopathy, his vision deteriorated at an accelerated rate. Mr. Szasz now has irreversible blurred vision, which is a precursor to blindness in both eyes.

58. At this time, other than Defendants named herein, Plaintiff is unaware of what additional medical provider(s) were responsible for ensuring adequate and congruent treatment while Mr. Szasz was in the *care* and custody of the County.

59. Defendants not only failed to prevent Mr. Szasz's foreseeable ocular complications, as order by the Court, they also failed to prevent and properly treat Mr. Szasz's broken thumb and open would, which resulted in a nearly fatal, and ongoing, MRSA infection, eventually spreading from his hand to his knee.

60. As detailed above, during the intake process, Mr. Szasz took notice of another inmate that was acting bizarre and aggressive, i.e., speaking to himself and yelling about the devil. Mr. Szasz was housed with this inmate in cell 26. At the time he was being housed with the inmate, Mr. Szasz expressed to a DOE housing deputy that he felt uncomfortable being housed with this particular inmate. Mr. Szasz's concerns were ignored and met with expletives. Based on information and belief, and Plaintiff's own warning, Defendant County and its DOE housing and classification deputies were on notice that DOE inmate was assaultive and unstable when they housed him with Mr. Szasz. Notably, DOE defendants also know Mr. Szasz is a vulnerable inmate that suffered from autism and severe co-morbidity conditions.

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61. A day or two later, on July 2, 2021, DOE inmate brutally attacked Mr. Szasz, claiming he needed to exorcise Mr. Szasz's demons. The inmate struck Mr. Szasz in his face multiple times breaking several facial bones. DOE inmate then viciously bit Mr. Szasz on the neck and hand. During the attack, the inmate bent back Mr. Szasz's thumb all the way and broke it.

62. Following the attack, Mr. Szasz was taken to the medical center where he was treated by Defendant Jonathan Symmonds, a registered nurse employed by the County. Defendant Symmonds failed to properly or thoroughly evaluate Mr. Szasz. Had Defendant Symmonds properly assessed Mr. Szasz, he would have observed the various broken facial bones and Mr. Szasz's thumb, which was hanging on by the skin. Mr. Szasz was sent back to housing with no follow up order or wound care treatment. Furthermore, Defendant Jonathan Symmonds failed to investigate who bit Mr. Szasz to determine whether DOE inmate was immunized or checked for infectious diseases.

63. The following day, July 3, 2021, Mr. Szasz was evaluated by Defendant Dr. Nas Rafi. Mr. Szasz complained of the immense pain in his right hand. However, his pleas were ignored again. Due to Mr. Szasz's level of complaints, Dr. Rafi permitted the nursing staff to order a thumb split but implied that it was not medically indicated. Defendant Rafi did not order follow up care or wound care despite Mr. Szasz's obvious broken bones and an *open* wound on the palm/thumb area of Mr. Szasz's right hand. Notably, Defendant Rafi and Symmonds knew that Mr. Szasz was housed in general population with other inmates, meaning the possibility of infection was high in a correctional setting.

64. For the next few days, Mr. Szasz constantly complained to unknown DOE correctional and medical staff regarding the immense pain he was feeling in his right hand. He also told unknown DOE staff that his thumb was getting worse and appeared infected. No one cared or attempted to provide care.

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65. Despite asking for medical help multiple times a day, Mr. Szasz was not seen by medical until July 8, 2021. He was summoned to the medical center to have the thumb splint applied. At that time, Mr. Szasz was evaluated by a different medical provider, Nurse Practitioner Joseph Carroll ("NP Carroll"). NP Carroll immediately observed that Mr. Szasz was suffering from a bone infection in his thumb. According to the medical note, Mr. Szasz's thumb/palm was red, swollen, oozing, and had no range of motion. Mr. Szasz was urgently sent to Tri-City Medical Center ("TCMC").

66. The doctors at TCMC diagnosed Mr. Szasz with flexor tenosynovitis. Flexor tenosynovitis is a severe infection within the hand. According to the TCMC medical providers, flexor tenosynovitis requires urgent treatment to preserve a viable and functioning thumb. Delayed diagnosis and treatment results in a poor recovery, which occurred in this case.

67. On that same day, Mr. Szasz underwent the first of four urgent surgeries for his hand. It was then determined that Mr. Szasz contracted MRSA in his hand. In short, Mr. Szasz contracted a deadly infection because Defendant medical providers ignored Mr. Szasz's obviously broken bone and open wound, coupled with their failure to order wound care throughout the six-day period, or investigate the origin of the bite to Mr. Szasz's hand.

68. While at TCMC, Mr. Szasz was treated by Dr. Seiden, an orthopedic surgeon. Dr. Seiden performed the urgent surgery and determined that Mr. Szasz had developed sepsis which complicated his diabetes. Dr. Seiden treated Mr. Szasz not only for MRSA but also for Mr. Szasz's serious diabetic complications. Mr. Szasz was treated at TCMC for the next week. Mr. Szasz's discharge paperwork clearly states Mr. Szasz wound was *nearly* closed. TCMC provided the jail with specific medical and wound care orders to be followed. The discharge order directed the County to follow up with Dr. Seiden in two-four weeks. The discharge

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paperwork also directed jail staff to provide Mr. Szasz with a different insulin regimen and Lumigan, the eye drops prescribed for Mr. Szasz's retinopathy.

69. When Mr. Szasz was transported back to VDF, Defendant Rafi reviewed the TCMC discharge paperwork. Defendant Rafi did not detail the medication needed nor did he prescribe the proper wound care as was used at TCMC. He also failed to prescribe medication to treat Mr. Szasz's retinopathy.

70. On August 6, 2021, Mr. Szasz was evaluated via telemedicine by Dr. Seiden, the orthopedic surgeon that performed the first surgery on Mr. Szasz's hand. Dr. Seiden opined that the wound was *not fully healed* and needed to be monitored **very closely.** At that time, Dr. Seiden did not think further surgical intervention was indicated but did order physical therapy to help Mr. Szasz regain mobility in his hand.

71. However, from that date on, Mr. Szasz's wound care decreased from once a day to once every few days. When Mr. Szasz did receive wound care it was below the standard of care because DOE medical staff failed to follow the wound care orders from TCMC, which included use of Bactrim and a particular adhesive bandage. Furthermore, despite the order for physical therapy, Mr. Szasz was wholly denied any treatment—not even one physical therapy session.

72. In short, during August of 2021 through May of 2022, Mr. Szasz required serious medical intervention with regard to his right hand and his diabetic complications.[1] According to Mr. Szasz, he submitted dozens of medical request forms to this effect.

73. As a punishment for his constant requests for medical intervention, on August 15, 2021, Mr. Szasz was moved to disciplinary housing.

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[1] Plaintiff is not in possession of medical records related to this period of time. Mr. Szasz was transferred to prison in May of 2022.

74. While housed in the hole, following Mr. Szasz's zealous attempts to obtain laser treatments for his retinopathy, the wound care for his right hand stopped. Mr. Szasz developed another MRSA infection in his right hand.

75. Due to limited medical records, Plaintiff is ignorant of the identities of the medical providers that failed to continue indicated treatment despite multiple requests from Mr. Szasz, and his father Leslie Szasz, regarding the worsening condition of Mr. Szasz's hand.

76. It took major oozing and no range of movement for medical staff to intervene. Ultimately, Mr. Szasz was sent to TCMC on August 19, 2021. Mr. Szasz underwent another urgent surgery. Again, the unknown TCMC doctor told Mr. Szasz that the webspace in his hand was growing MRSA indicating that he was not properly monitored or treated at VDF. The unknown TCMC doctor told Mr. Szasz that he would need continual oversight for approximately 2-3 weeks to ensure there was not a re-occurrence of an infection. However, against the advice of the unknown medical doctor, DOE deputies, at the direction of DOE medical staff, including Defendant Rafi, removed Mr. Szasz from TCMC against medical directive.

77. Based on an incomplete medical record from the jail, Plaintiff is unaware of the follow-on care, if any. However, prior to Mr. Szasz's transfer to prison, Mr. Szasz underwent two more surgeries, totaling to four surgeries for his right hand. To date, Mr. Szasz has no movement if his right thumb, mainly due to wholly inadequate care and a complete failure to provide physical therapy. Even today, Mr. Szasz's entire right hand is fraught with pain. The pain is now so severe and prolonged that Mr. Szasz is suffering from debilitating depression.

78. Moreover, based on Defendants' failures, Mr. Szasz has suffered from irreparable blindness and loss of use in his right hand.

79. Specifically, ss a result of Defendants' callous and indifferent behavior, Mr. Szasz has a permanent disfigurement on his hand and has no use of

his thumb. The pain that continues today is crippling. The same occurred with Mr. Szasz's knee, however, Plaintiff is currently ignorant of the details given Mr. Szasz's recent imprisonment.

80. As a result of the wholly inadequate treatment described above, Mr. Szasz also suffered from emotional and mental distress resulting from the incident in the form of nightmares, sleep disturbances, night sweats, loss of appetite, and loss of energy. Mr. Szasz continues to feel panic and anxiety when thinking about the preventable attack and the apathetic follow-on care provided to him. Mr. Szasz feels the county purposefully allowed him to be permanently disfigured because they did not want to pay for the surgical consult that was ordered, nor did it want to pay for the continuous laser treatments as indicated by Mr. Szasz's treating physician.

81. Due to the conduct described above, Mr. Szasz is entitled to money damages pursuant to 42 U.S.C. section 1983 to compensate him for his injuries and for the violation of his constitutional and civil rights.

82. In addition to compensatory, economic, consequential, and special damages, Plaintiff is entitled to punitive damages against each Defendant under 42 U.S.C. section 1983, in that the actions of each were done intentionally and with the intent to violate Plaintiff's right, or was done with a reckless disregard or wanton disregard for Mr. Szasz's constitutional rights.

V.

SECOND CAUSE OF ACTION

[Failure to Provide Reasonable Accommodations to Incarcerated people with Disabilities – ADA, Rehabilitation Act, Unruh Act, Cal. Civ Code §§51 *et seq.*, California Government Code Claim §1135]

(By Brian Szasz Against All Defendants)

83. Plaintiff realleges and incorporates by reference all paragraphs stated above, as though fully set forth herein.

84. Under controlling law, the County and CHP, must create and maintain a system to adequately identify and treat inmates with known disabilities. Mr. Szasz's co-morbidity conditions render him a disabled person.

85. As detailed above, all Defendants failure to provide medical accommodations to Mr. Szasz in the form a retina laser treatments is a violation of Mr. Szasz's rights under the constitution as a disabled citizen.

86. Additionally, housing Mr. Szasz in the hole simply because he is disabled and in need of constant medical attention is cruel, sadistic, and unconstitutional. Furthermore, denying him routine activities because he is disabled and in need of constant medical attention is cruel, sadistic, and unconstitutional.

87. Due to the conduct described above in detail, Mr. Szasz is entitled to money damages pursuant to 42 U.S.C. section 1983 to compensate him for his injuries and for the violation of his constitutional and civil rights.

88. In addition to compensatory, economic, consequential, and special damages, Plaintiff is entitled to punitive damages against each Defendant under 42 U.S.C. section 1983, in that the actions of each were done intentionally and with the intent to violate Plaintiff's rights or was done with a reckless disregard or wanton disregard for Mr. Szasz's constitutional rights.

VI.

THIRD CAUSE OF ACTION

Failure to Provide Adequate Medical Care and Training – 14th Amendment and Article 1, Sections 7 and 17 of California Constitution

[By Brian Szasz Against San Diego County and CHM]

89. Since 2014, the county has faced a steady drum beat of calls by Disability Rights California, Grand Juries, and by dozens of individual plaintiffs, for failing to properly screen, assess, treat, and house medically unstable inmates. Recently, the county has been placed under a magnifying glass due to the countless

of preventable injuries and deaths that resulted from untreated medical complications.

90. In fact, in April 2018, Disability Rights California, the state's designated protection and advocacy system for people with disabilities, published an investigative report regarding San Diego County jails. The report states, "We found that the County's jail system subjects inmates with medical and mental health needs to a grave risk of psychological and other harms by failing to provide adequate treatment… insufficient staffing and lack of other critical resources have caused these problems to persist." The report also stated, "We have found that existing systems of jail oversight have failed."

91. More recently, the California State Auditor inspected the County jails and issued a scathing report urging the State Legislature to *force* the County to make meaningful changes. The report starts off by stating:

> From 2006 through 2020, 185 people died in San Diego County's jails—one of the highest totals among counties in the State. The high rate of deaths in San Diego County's jails compared to other counties raises concerns about underlying systemic issues with the Sheriff's Department's policies and practices. In fact, our review identified deficiencies with how the Sheriff's Department provides care for and protects incarcerated individuals, which likely contributed to in-custody deaths. These deficiencies related to its provision of medical and mental health care and its performance of visual checks to ensure the safety and health of individuals in its custody. In light of the ongoing risk to inmate safety, the Sheriff's Department's inadequate response to deaths, and the lack of effective independent oversight, we believe that the Legislature must take action to ensure that the Sheriff's Department implements meaningful changes.

92. In February of 2022, the County and CHP were hit with a class action lawsuit based on the wholly inadequate policies and practices Defendants maintain despite knowing that inmates' injuries and deaths could/can be prevented. (Plaintiff incorporates the Class Action Complaint herein by reference.)

93. Specifically, as it applies to Mr. Szasz's injuries, the County and CHP have maintained constitutionally inadequate intake practices which fail to identify

inmates suffering from severe co-morbidity conditions. The County and CHP have also failed to implement protocols that ensure that inmates that are later identified with co-morbidity conditions are congruently treated for all severe conditions. Defendants have also failed to ensure that the medical treatments inmates receive outside of custody, by their primary care physicians, remain consistent and congruent when inmates are detained in jail. Lastly, Defendants failed to implement protocols ensuring that inmates who were given a referral to a specialist get treated by the specialist. Generating a referral does not relieve Defendants of their duty to provide adequate care. Rather, the County and CHP intentionally failed to implement follow-up protocols that ensure referrals and consultations occur, and in a timely manner.

94. Plaintiff is at the whim of local publications in order to establish a pattern of inadequate medical care as it pertains to diabetic mismanagement.

95. In 2019, the *San Diego Union Tribune* found that, 'reports show multiple inmates dying from treatable conditions like diabetes…" Those reports were not published but will be requested during discovery.

96. As detailed in the *San Diego Union Tribune* found in February of 2021, inmate Gil Gilbert's co-morbidity conditions, including diabetes, was known by jail staff but was ignored. Staff denied him proper medication. Mr. Gilbert died in jail as a result of Defendants' inadequate medical care.

97. In in 2014, Jerry Cochran died in jail from untreated diabetic ketoacidosis. On September 16, 2014, Cochran was brought to the Jail and was so weak that deputies had to carry him inside. Although Cochran went through initial medical screening and was wearing a medical bracelet alerting staff that he had diabetes, Cochran was placed in a holding cell with several other people. Cochran collapsed in the cell and died, having never received any insulin or other treatment to address his diabetic ketoacidosis.

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98. Class action plaintiff, Dunsmore, was "receiving four shots of insulin daily to treat his diabetes. However, shortly after he arrived at the Jail, medical providers terminated his daily insulin shots and instead provided him with insulin shots only after his blood sugar was measured over 250 mg/dL. This change caused DUNSMORE to become fatigued, lethargic, thirsty, and in need of frequent urination. This sort of diabetes management regimen is completely inconsistent with modern standards of care, including in detention settings."

99. Lastly, the continued and repeated failures to provide Mr. Szasz's adequate and correct insulin (and eyedrops) by itself creates a pattern of similar conduct because Defendants' failures were made repeatedly, by different medical providers, and over a long period of time.

100. Furthermore, knowing that inmates are not receiving the necessary treatment, the County and CHP have doubled down on their indifference by intentionally understaffing the jails. According to the class action lawsuit, "An October 2021 letter from the Service Employees International Union ('SEIU') Local 221, which represents Jail health care workers, to the Citizens Law Enforcement Review Board ('CLERB') explained that understaffing created "dangerous and inhumane" conditions for incarcerated people and medical staff alike. As of late 2021, 216 medical positions at the Jail—more than 41% of authorized positions—remained vacant, and existing medical staff have been on mandatory overtime for months."

101. Lastly, as confirmed by various Grand Juries, the ACLU, and the State Auditor, the County has not only failed to implement meaningful policies, it, and its contracted partner, CHP, have also failed to train its staff to provide reasonable and timely medical care.

102. In addition to ignoring identified policy deficiencies pointed out by the Grand Juries and the State Auditor, the county also remained steadfast in its decision to out-source mental health treatment. Specifically, at all times relevant

herein the county attempted to contract its non-delegable duty to a third-party medical group, CHP. The inadequate medical care referend above is equally attributable to CHP's failure to train and supervise its medical providers. Specifically, CHP intentionally fails train its providers regarding adequate care or continuity of care because they are "independent contractors" and believed to have been adequately trained on during medical school and residency. The County, knowing this is CHP's method of business, also fails to adequately train the providers, providing only one six-hour training course to cover hundreds of medical policies and procedures, including intake screenings, housing options, and treatment options for inmates with serious co-morbidity conditions. As such, the medical providers are untethered and not trained on the County's polices and/or the various appropriate treatment options for inmates suffering from obvious and serious medical conditions. Consequently, there is no continuity of care or a standardized process for identifying and treating inmates such as Mr. Szasz.

103. Because the County and CHP were on notice that its medical policies and training were constitutionally inadequate, yet failed to improve it, Plaintiff is entitled to money damages pursuant to 42 U.S.C. section 1983 to compensate him for the repeated violation of his constitutional and civil rights. Specifically, Defendants are liable and responsible for Mr. Szasz's loss of use of his right hand and the loss of vision that will assuredly lead to total blindness. Defendants are also responsible for the severe emotional distress that Mr. Szasz has endured as a result of Defendants' conduct.

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VII.

FOURTH CAUSE OF ACTION

Negligence

[By Brian Szasz Against NP Lee, Dr. Montgomery, RN Symmonds, Dr. Rafi, RN Hood, San Diego County, CHP, and DOE Deputy/Nurse Defendants 1-10]

104. Plaintiff realleges and incorporates by reference all paragraphs stated above, as though fully set forth herein.

105. Defendants were charged with the duty to act in accordance with the laws of state, the Constitution, and Ninth Circuit precedence. Each Defendant has a particularized duty, per the law and per county policy, to protect inmates from known assaultive inmates and to summon adequate medical care when they are on notice that an inmate is in need of such care. Defendants are charge with the duty to act as a reasonable deputy or nurse in the same or similar circumstances.

106. Defendant DOE housing and classification deputies were negligent because they were directly on notice that DOE Inmate was violent and unstable. Regardless of the knowledge that DOE inmate posed a threat to other inmates if housed in mainline housing, Defendants acted negligently by housing Mr. Szasz with DOE inmate.

107. DOE deputies that Mr. Szasz confronted and requested for medical treatment were also negligent for their intentional failure to summon immediate medical care for Mr. Szasz's broken bones, MRSA, and diabetic complications, including his retinopathy.

108. DOE deputies that were responsible for re-housing Mr. Szasz due to his "excessive" complaints for medical attention were not only negligent but also sadistic and cruel in their failure to summon and prevent adequate medical care.

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109. DOE Deputies, and DOE Medical Defendants, including Defendant Rafi, that were responsible for removing Mr. Szasz from TCMC against medical directive were additionally negligent for failure to summon, and for preventing, immediate medical care.

110. Pursuant to California Government Code Section 845.6, public employees, and the public entity itself, including CHP, are also liable for Mr. Szasz's injuries because Defendants knew he was in need of immediate medical care yet not only denied that care, but prevented it.

111. As detailed above, medical defendants Lee and Montgomery each knew that Mr. Szasz required immediate medical care in the form of diabetic management. They also knew that Mr. Szasz required an urgent referral for retinopathy management. Both Defendants fell below the standard of care by ignoring Mr. Szasz's medical conditions. It appears by the limited medical records, that Defendants Lee and Montgomery failed to take any action, however if this Court concludes that the minimal action taken equates to medical malpractice, Plaintiff sues them herein for their medical negligence in failing to advocate and adequately treat Mr. Szasz.

112. Pursuant to California Government Code Section 845.6, public employees, and the public entity itself, including CHP, are also liable for Mr. Szasz's injuries because Defendant Lee and Montgomery knew Mr. Szasz was in need of immediate medical care yet denied that care.

113. As detailed above, medical Defendants Symmonds, Rafi, and Hood, each knew that Mr. Szasz was suffering from prolonged infection and injury in his right hand. Each Defendant also knew that Mr. Szasz's blood sugar level was out of control and yet each Defendant failed to administer, or have administered, the correct diabetic medication for Mr. Szasz's insulin and retinopathy needs. It appears by the limited medical records, that Defendants Symmonds and Hood failed to take any action and therefore failed to summon immediate medical care.

114. However, Defendant Rafi did provide care, albeit grossly below the standard of care. Defendant Rafi failed to treat Mr. Szasz's obvious broken bones and bone infection. He routinely failed to order wound care. He also failed to order and ensure the proper medication regimen as ordered by the TCMC doctors. Lastly, Defendant Rafi failed to take any meaningful action to treat Mr. Szasz's ocular complications. For this wholly inadequate and sub-standard treatment, Plaintiff sues Defendant Rafi herein for his medical negligence in failing to advocate and adequately treat Mr. Szasz. CHP is variously liable for their employees' intentional conduct.

115. In committing the acts alleged above, the individual Defendants acted maliciously and/or were guilty of a wanton and reckless disregard for Mr. Szasz's rights and feelings and by reason thereof he is entitled to exemplary and punitive damages in an amount to be proven at trial.

VIII.

FIFTH CAUSE OF ACTION

Intentional Infliction of Emotional Distress

[By Brian Szasz Against DOE Deputy/Nurse Defendants 1-10, Nas Rafi, and CHP]

116. Plaintiff realleges and incorporates by reference all paragraphs stated above, as though fully set forth herein.

117. Defendant DOE housing and classification deputies were grossly negligent because they were directly on notice that DOE Inmate was violent and unstable. Regardless of the knowledge that DOE inmate posed a threat to other inmates if housed in mainline housing, Defendants acted negligently by housing Mr. Szasz with DOE inmate. Intentionally housing a vulnerable inmate with a dangerous and unstable inmate shocks the conscience of a normal and reasonable citizen.

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118. Moreover, DOE deputies that were responsible for re-housing Mr. Szasz due to his "excessive" complaints for medical attention were not only negligent but also sadistic and cruel in their failure to summon and prevent adequate medical care. This behavior also shocks the conscience as it is a universal understanding that correctional staff should not penalize inmates for requesting immediate medical intervention.

119. DOE Deputies, and DOE Medical Defendants, including Defendant Rafi, that were responsible for removing Mr. Szasz from TCMC against medical directive intentionally caused Mr. Szasz emotional distress because removing him under those circumstances was against a medical directive and resulted in further harm and injury.

120. Lastly, based on the limited records provided to Mr. Szasz, it appears Defendant Rafi was primarily in charge of Mr. Szasz's medical care. It was clear that he knew, along with other DOE medical officials, that Mr. Szasz required laser treatment in order to prevent blindness. Defendant Rafi knew the significance of the treatment because he read Mr. Szasz's medical records from at least two ocular doctors that were actively treating Mr. Szasz. Defendant Rafi was also well aware of the Court Order requiring Mr. Szasz to receive the laser treatments indicated. Despite this knowledge, and the knowledge that Mr. Szasz would go blind without the treatment, Defendant Rafi intentionally refused the treatment thereby knowingly causing Mr. Szasz extreme anxiety and duress. For these reasons, CHP is variously liable for their employees' intentional conduct.

121. In committing the acts alleged above, the individual Defendants acted maliciously and/or were guilty of a wanton and reckless disregard for Mr. Szasz's rights and feelings and by reason thereof he is entitled to exemplary and punitive damages in an amount to be proven at trial.

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IX.

SIXTH CAUSE OF ACTION

Battery

[By Brian Szasz Against DOE Inmate]

122. Plaintiff realleged and incorporates by reference all the paragraphs stated above, as though fully set forth herein.

123. By committing the acts described above in regards to attacking and biting Mr. Szasz, each act was done without consent or justification.

124. DOE inmates conduct was done for the sole purpose of causing severe harm, distress, injury, fear, and pain, or at the very least, was done in reckless disregard of that probability.

125. As a result of these acts, Plaintiff suffered from prolonged physical pain and emotional distress, entitling him to damages in an amount to be proven at trial.

126. In committing the acts alleged above, DOE Inmate acted maliciously and/or were guilty of a wanton and reckless disregard for the rights and feelings of Plaintiff and by reason thereof he is entitled to exemplary and punitive damages in an amount to be proven at trial.

X.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for judgement against Defendants, for each and every cause of action, as follows:

1. For compensatory, general, and special damages against each defendant, jointly and severally, in an amount according to proof;

2. For punitive and exemplary damages against each individually named defendant in their individual capacity in an amount appropriate to punish defendants and deter others from engaging in similar misconduct;

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3. For costs and reasonable attorney's fees pursuant to 42 U.S.C. section 1988 and as otherwise authorized by statute or law;

4. For any further relief that the Court may deem appropriate.

XI.

DEMAND FOR JURY TRIAL

Demand is hereby made by for a jury trial.

Respectfully submitted,

PHG Law Group

Dated: July 19, 2022

by: *s/ Danielle R. Pena*
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